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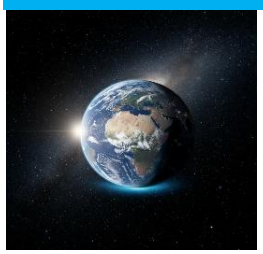

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Psychosomatic Disorders and the Physician-Patient Relationship - A Review

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Abstract

Introduction and Aim: Psychosomatic disorders present a significant challenge in medicine, where somatic symptoms are closely connected to psychological and social factors. Family physicians play a central role in recognizing and managing these patients, whose complex needs often lead to repeated consultations and increased healthcare utilization. This review aims to analyze the physician-patient relationship in the care of patients with psychosomatic disorders and its impact on diagnosis and treatment.

Materials and Methods: The study is a literature review including scientific articles, monographs and textbooks in family medicine, psychosomatics and clinical psychology.

Literature was searched in PubMed, Scopus, Web of Science and Google Scholar. Publications were selected based on relevance, scientific value and focus on physician-patient interaction, communication, patient personality traits and the role of Balint groups.

State of Knowledge: Psychosomatic disorders manifest in cardiovascular diseases, peptic ulcers, eating disorders, skin diseases and sleep disorders with psychological factors influencing symptom development and course. Effective care relies on a biopsychosocial approach, empathetic communication and physician awareness of relational dynamics. Participation in Balint groups enhances empathy, improves patient communication and reduces physician burnout.

Conclusions: The physician-patient relationship is a key therapeutic tool in psychosomatic care. Holistic treatment addressing both somatic and psychological needs, combined with effective communication and physician self-awareness, improves patient outcomes and fosters long-term therapeutic engagement.

Keywords**:** doctor-patient relationship; communication; stress; mental health

Introduction

Psychosomatic disorders represent a significant challenge for contemporary medicine, particularly in the field of primary health care. They refer to situations in which a patient experiences real, often severe somatic symptoms that are closely associated with psychological, emotional and social factors, in the absence of sufficient organic explanation or with symptom severity disproportionate to identified somatic changes [1].

The family physician, as the first and often the only medical professional remaining in long-term contact with the patient, becomes a key figure in the recognition and management of patients with psychosomatic disorders. These patients are characterized by frequent visits, multiple complaints, a high level of health-related anxiety and significant functional and social burden.

The significance of psychosomatic disorders extends beyond the purely clinical dimension. These patients generate substantial system-level costs are more frequently referred for diagnostic tests and specialist consultations and at the same time less often experience subjective improvement. Diagnostic difficulties and the lack of clear treatment effects contribute to frustration on both the patient's and physician's side, increasing the risk of misunderstandings, conflicts and professional burnout [1,2].

In this context, increasing attention is being paid to the necessity of a comprehensive, biopsychosocial approach to the psychosomatic patient. Understanding the role of psychological and relational factors in the development and maintenance of somatic symptoms constitutes the foundation of effective care in family medicine practice. This review addresses the issue of patients with psychosomatic disorders, focusing on their functioning within the primary health care system and on the diagnostic and therapeutic challenges faced by family physicians.

Materials and Methods

This is a review study analyzing literature on the physician-patient relationship in the care of patients with psychosomatic disorders. The material included scientific articles, monographs and textbooks in family medicine, psychosomatics and clinical psychology.

Literature was searched in PubMed, Scopus, Web of Science and Google Scholar. Publications were selected based on their relevance, scientific value and relation to the topic. The analysis focused on physician-patient interaction mechanisms, the role of communication, patient personality traits and the significance of physicians' participation in Balint groups.

Results

Cardiovascular Diseases as Examples of Psychosomatic Disorders

Cardiac function is closely related to a person's mental state, therefore, cardiovascular diseases have long occupied an important place in psychosomatic research. Coronary artery disease, myocardial infarction and arterial hypertension are among the most common causes of morbidity and mortality and their etiology is multifactorial. It includes not only genetic and somatic predispositions, comorbidities and lifestyle factors, but also psychological factors, particularly chronic stress and emotional regulation strategies.

One of the best-known psychological risk factors for heart disease is Type A personality. It is characterized by excessive ambition, haste, a strong need for achievement, competitiveness, a tendency toward dominance and aggressiveness and a chronic sense of time pressure [3-5]. Individuals with these traits often strongly identify with their work, overestimate their capabilities and function under prolonged tension, which promotes the development of coronary artery disease and myocardial infarction. Increasing attention is also paid to Type D personality, associated with negative affectivity and social inhibition. Research indicates that it is linked to a more severe course of cardiovascular disease and higher mortality [4,6-8].

However, growing importance is attributed not so much to personality types themselves as to emotions, particularly anger and hostility. Suppressed anger leads to chronic activation of the sympathetic nervous system, increased secretion of catecholamines and cortisol and persistent vasoconstriction, which promotes the development of hypertension and coronary artery disease [9-11]. Under conditions of long-term stress, the heart remains in a state of constant mobilization without the opportunity for regeneration, which over time leads to structural and functional changes in the cardiovascular system [12,13].

Arterial hypertension is the most common cardiovascular disease and one of the leading causes of premature death worldwide [14]. In addition to biological factors, chronic stress and personality traits such as anxiety, hostility, excessive self-control, difficulties in expressing emotions and problems with conflict resolution play an important role. Family and socio-cultural factors are also significant, including communication patterns based on conflict avoidance and work performed under conditions of high responsibility and pressure [15].

A particularly striking example of an acute psychosomatic reaction is Takotsubo syndrome, the so-called “broken heart syndrome”, which occurs in response to sudden, extreme emotional experiences and confirms the strong link between the psyche and cardiac function [16].

Treatment of heart disease in psychosomatic patients may be difficult due to low motivation, skepticism toward therapy and minimization of symptoms. Therefore, the need for a biopsychosocial approach is increasingly emphasized, combining pharmacotherapy and lifestyle modification with psychological interventions. Consideration of emotions, stress and interpersonal relationships is crucial both in prevention and in the effective treatment of cardiovascular diseases.

Peptic Ulcer Disease as an Example of a Psychosomatic Disorder

Peptic ulcer disease (PUD) constitutes a classic example of a condition in which psychosomatic factors play a significant role in its development and course. Research in psychosomatic medicine and behavioral medicine indicates that the gastrointestinal system is particularly sensitive to the influence of emotions and chronic psychological stress. Strong emotional tension, suppressed feelings, long-term internal conflicts or a lack of effective coping strategies may lead to functional disorders of the stomach and duodenum, even in the absence of identifiable organic causes [17,18].

Symptoms such as abdominal pain, nausea, gastric cramps or diarrhea often occur in stressful situations and may be experienced from early childhood. This relationship is confirmed by epidemiological studies demonstrating a significant association between high levels of psychological stress and an increased risk of peptic ulcer disease, regardless of Helicobacter pylori infection or the use of nonsteroidal anti-inflammatory drugs [18].

Psychophysiological studies indicate that individuals who suppress anxiety and anger exhibit increased gastric secretory activity [19]. Long-term disturbances in the regulation of gastric juice secretion, especially under chronic stress, may contribute to damage of the mucosal barrier and increase susceptibility of the mucosa to hydrochloric acid and pepsin, leading to ulcer formation [20]. For this reason, the importance of verbal expression of emotions and reduction of psychological tension in treatment is emphasized as this may reduce the risk of disease recurrence [19].

A significant contribution to understanding the psychosomatic basis of PUD was made by Franz Alexander, who emphasized the role of unconscious emotional conflicts in the disease's etiology [21]. According to this concept, patients with peptic ulcer disease experience a conflict between the need for dominance and independence and a tendency toward submission and dependence. Suppressed aggression, resulting from a lack of social acceptance, leads to increasing psychological tension that favors the development of somatic symptoms.

Two types of PUD patients are distinguished: the active type, characterized by excessive ambition, overload with duties and increased activity and the passive, submissive type, marked by dependence and passivity. In both cases, the disease develops in situations of long-term frustration of basic emotional needs and escalating internal conflict [22].

From a medical perspective, peptic ulcer disease affects approximately 4% of the population [23] and is defined as erosions or submucosal damage of the gastric or duodenal mucosa [24,25]. Although the discovery of Helicobacter pylori by Marshall and Warren in 1983 [26] significantly changed the approach to PUD treatment, its multifactorial nature is now increasingly emphasized, involving interactions between biological, psychological and environmental factors [25,27-30].

The main risk factors include smoking, coffee consumption, use of nonsteroidal anti-inflammatory drugs (NSAIDs) and Helicobacter pylori infection [25,31-33]. Despite widespread carriage of this bacterium, not all individuals develop peptic ulcer disease, which indicates the important role of psychosocial factors. According to Levenstein, these factors may account for 30-65% of PUD cases [27]. Studies also demonstrate associations between the disease and depression, chronic stress, occupational burnout and traumatic life events [30,33,34].

Contemporary treatment of PUD is primarily based on pharmacotherapy. However, in patients with a pronounced psychosomatic component, psychotherapy is also of significant importance. Psychotherapeutic interventions - individual, group or family-based - may contribute to the reduction of emotional tension, improvement in stress coping and decreased risk of recurrence and chronic disease course.

Eating Disorders as Examples of Psychosomatic Disorders

Eating disorders represent significant psychosomatic problems related to gastrointestinal functioning and emotional regulation. In recent decades, a clear increase in their prevalence has been observed, confirming growing interest among researchers and clinicians. Both anorexia nervosa and bulimia nervosa are multifactorial in nature and reveal a close relationship between the psychological sphere and somatic symptoms [19].

Although the symptoms of eating disorders manifest primarily in the domain of eating behavior, they result from complex psychological, emotional and interpersonal mechanisms, often linked to developmental experiences and the patient's current life situation. Eating serves not only a biological function but also an emotional and symbolic one - it regulates tension, communicates needs and compensates for emotional deficits. Difficulties in emotional regulation correlate with the severity of eating disorder symptoms, including emotional eating and binge eating and emotional responses to food-related stimuli differ from those of healthy individuals, confirming the role of emotional factors in maintaining the disorder [35-38].

Anorexia Nervosa

Anorexia nervosa most commonly affects adolescent girls and is often interpreted as a reaction to fear of adulthood, autonomy and developmental changes. From a psychosomatic perspective, the disorder may represent an attempt to regain control over one's body and emotions. Patients frequently exhibit denial of illness, distorted body image and numerous somatic symptoms resulting from physical emaciation [21].

Bulimia Nervosa

Bulimia nervosa is characterized by binge-eating episodes followed by feelings of guilt and compensatory behaviors. Eating serves as a short-term means of reducing tension and suppressing emotions, but quickly leads to symptom intensification and perpetuation of the vicious cycle of the disorder. Patients are characterized by emotional lability, impulsivity and difficulties in coping with stress [21].

Treatment

Treatment of eating disorders requires an interdisciplinary approach. Psychotherapy plays a key role, including psychodynamic therapy, cognitive-behavioral therapy and systemic family therapy. The aim of treatment is not only normalization of eating behaviors but also improvement of emotional regulation, interpersonal relationships and reduction of chronic stress [19].

Skin Diseases as Examples of Psychosomatic Disorders

Skin diseases are common conditions that may cause significant discomfort and reduce patients' quality of life. Despite the widespread use of pharmacological therapies and topical preparations, in some patients skin symptoms have a significant psychosomatic basis. In such cases, improvement in the patient's emotional state may play a crucial role in alleviating symptoms. A particularly strong relationship between psychological factors and disease course is observed in psoriasis and atopic dermatitis.

Psoriasis is a chronic inflammatory skin disease characterized by papular lesions and systemic symptoms, affecting 2-4% of the population. Treatment of moderate to severe disease includes systemic medications such as acitretin, cyclosporine and methotrexate, as well as topical preparations including creams and ointments [39,40]. The pathophysiology of the disease is associated with activation of Th lymphocytes, which induce inflammatory responses and stimulate the production of pro-inflammatory mediators, leading to endothelial dysfunction and platelet activation [41]. Although psoriasis may have a genetic component, symptoms often emerge in stressful situations. Negative emotions such as fear, depression or excessive arousal increase the risk of disease exacerbation, particularly in the presence of pruritus [21].

Atopic dermatitis (AD) is a chronic inflammatory skin disease characterized by pruritus, dryness and erythema. It occurs in both children and adults [42]. The disease most often manifests in childhood and patients with AD are also more susceptible to the development of allergic diseases. Treatment is primarily based on topical corticosteroids in the form of ointments, creams, gels or lotions, selected individually depending on symptom severity [43].

In children, psychosomatic factors associated with AD often correlate with the mother-child relationship. A lack of parental satisfaction with caregiving and physical contact may lead to an increased need for closeness in the child and heightened skin sensitivity. In adults, important

psychosomatic factors include low self-esteem and conflicts in intimate relationships. Furthermore, the localization of skin lesions may depend on the level of emotional tension - under high tension, lesions most often occur on the chest, hips, shoulders and thighs, whereas under lower tension they are observed mainly on the head and face [21].

Sleep Disorders as Examples of Psychosomatic Disorders

Sleep disorders are a common problem among individuals suffering from psychosomatic diseases. Factors such as chronic stress, excessive workload and irregular daily rhythms may disrupt sleep, leading to dysregulation of the body's biological clock. Sleep includes REM phases, associated with brain activity similar to wakefulness and dreaming and NREM phases, representing deep sleep. In adults, these phases alternate in cycles of approximately 90 minutes, with REM sleep lengthening over the course of the night [44]. Lack of REM sleep may result in deterioration of well-being and the occurrence of nervous disorders [21].

Sleep disorders affect between 4.4% and 48% of the population and include primarily insomnia, hypersomnia, parasomnias and sleep-related fears and nightmares [44,45]. Insomnia often develops in response to stress and may lead to so-called "bed phobia", increasing anxiety and daytime fatigue [21].

Existing research demonstrates a strong correlation between psychosocial stress, sleep disorders and the severity of psychosomatic symptoms. Chronic stress leads to shortening of REM and deep sleep phases, increasing the risk of somatic complaints such as musculoskeletal pain, digestive disturbances or cardiovascular problems [46-48]. Sleep disorders may, in turn, intensify the impact of stress on psychosomatic symptoms and individuals with mental disorders more frequently report reduced sleep quality [49]. Psychosomatic models indicate that chronic stress and negative emotions promote the development of chronic insomnia and sleep rhythm disturbances [50,51].

Therapy for sleep disorders should primarily be based on non-pharmacological methods such as cognitive-behavioral therapy, autogenic training and education on sleep hygiene. Hypnotic medications are recommended only for short-term use, as they may suppress REM sleep, lead to accumulation of so-called "sleep debt" and increase the risk of dependence [21]. Treatment effectiveness also depends on providing the patient with support and a sense of understanding

from the physician, as hope and acceptance promote regeneration, whereas lack of support and chronic stress exacerbate psychosomatic symptoms.

Psychosomatic Approach to the Patient

Patients with psychosomatic disorders, like other patients, consult family physicians seeking pharmacological support. However, their care also requires consideration of a specific approach that takes into account the patient's emotional state.

The psychosomatic approach treats somatic medicine and psychology as an integrated whole, emphasizing that physical symptoms may reflect hidden psychological conflicts and psychosocial problems [52]. Unlike the traditional biological model of treatment, psychosomatic medicine takes into account the patient's personality, life experiences and existential crises that may influence disease development and course. Somatic treatment is therefore not an end in itself - understanding the meaning of illness in the context of the patient's life and building relationships based on trust and partnership become essential.

Characteristics of the Patient with Psychosomatic Disorders

The psychosomatic patient displays a number of characteristics that influence the course of the visit and the manner in which consultations are conducted in family medicine practice. These include unusual behaviors manifested by atypical and inappropriate reactions that may surprise the physician. Overactivity is also common, expressed as psychomotor agitation, excessive talkativeness and difficulty maintaining attention. In some patients, withdrawal is observed, understood as limited communicativeness, emotional closure and avoidance of eye contact. A characteristic feature is also excessive focus on symptoms, involving repeated return to complaints despite the lack of objective medical confirmation.

Such behaviors may evoke specific reactions in physicians, such as irritation, amusement or minimization of reported problems, which may consequently lead to a sense of misunderstanding on the patient's part.

Psychosomatic Interview

In clinical practice, a psychosomatic approach requires empathy, sensitivity and active listening from the physician, referred to as the "third ear" - the ability to perceive the emotional meaning of the patient's statements while they are describing their complaints. The psychosomatic interview differs from the general medical interview limited to symptoms, as it allows the physician to become familiar with the patient's life, conflicts and emotional tensions, as well as to identify psychosocial determinants of illness at an early stage [21].

Patients with psychosomatic disorders often belong to a group in which significant improvement in reported symptoms is not observed. They frequently do not understand the nature of their complaints, which complicates the diagnostic and therapeutic process. For this reason, the physician plays a key role in supporting the patient in understanding the mechanisms underlying the disorder. This understanding is shaped by the nature of the physician-patient relationship, including the way therapeutic contact is established and maintained, as well as the manner in which the medical interview is conducted.

During a standard medical interview, the physician focuses primarily on identifying symptoms that enable diagnosis. In the case of patients with psychosomatic disorders, however, it is important that the patient understands the causes of their complaints, as this allows them to understand why the physician proposes additional psychiatric or psychological consultations.

In the psychosomatic interview, three areas of analysis are particularly important: time, place and persons accompanying symptom occurrence. Considering these elements allows for a better understanding of the conditions of reported complaints and their relationship to the patient's emotional functioning.

Temporal analysis primarily involves determining the moment when symptoms first appeared and the circumstances surrounding their onset. The physician should ask not only about the beginning of complaints but also about life events that occurred at that time, both in the family and personal spheres. All changes are relevant, regardless of whether they were negative, such as illness or loss of a loved one or positive, such as starting a new job, which may also be associated with increased stress. In clinical practice, it is also justified to consider the period preceding symptom onset - approximately one year earlier - to identify prior changes or burdens.

Significant life events may lead to reorganization of the entire family system, imposing new roles and responsibilities on the patient that they may not always be able to manage. Although it is not always possible to clearly locate such experiences in time, they often constitute an important context for the development of psychosomatic symptoms.

Another element of the interview is analysis of the place where symptoms occur or intensify. The physician should determine whether complaints appear in specific situations or environments, such as crowded places or spaces lacking contact with others. In some patients, especially those with anxiety disorders, certain locations may promote symptom escalation. These questions aim to help the patient identify situations in which psychological tension increases, which in turn is associated with intensification of somatic complaints.

An important area of the interview is also the presence of other people at the time symptoms occur. The physician should ask whether complaints appear in the presence of specific individuals and how these individuals react to the reported symptoms. This information allows assessment of whether environmental reactions may reinforce or alleviate symptoms. In some patients, somatic symptoms may unconsciously be associated with receiving attention, support or care, which promotes their persistence. Conversely, lack of response from the environment may influence how the patient experiences their complaints.

The patient's responses to these questions are intended to help them become aware of the relationship between emotional tension, life situations and the occurrence of somatic symptoms. On this basis, the physician can explain the link between emotional processes and the body's physiological reactions, which justifies proposing psychiatric or psychological consultation aimed at assessing and supporting the patient's emotional functioning.

Standard statements such as: "From a medical point of view, you are healthy, there is nothing more I can do here, I would advise you to see a psychiatrist or psychologist" often evoke anxiety and a sense of rejection.

The use of more empathetic and educational formulations may improve communication effectiveness:

1. “From a medical point of view, you are healthy…” - refer to holistic medicine, explain the connections between emotions and physical symptoms, use circular questions,

2. “…there is nothing more I can do here…” - emphasize that the physician is not withdrawing from contact and that referral to another specialist is consultative in nature,

3. “…I would advise you to see a psychiatrist or psychologist.” - link the consultation to previously provided information and reassure the patient about the possibility of returning to the family physician.

Such an approach fosters relationship building, increases the patient’s sense of understanding and facilitates implementation of an appropriate diagnostic and therapeutic pathway. Table 1 presents the impact of the physician’s communication style on the reactions of patients with psychosomatic disorders, along with an example of message reformulation.

Table 1. Impact of physician communication style on reactions of patients with psychosomatic disorders

Communication element	**Standard physician’s wording**	**Possible patient reaction**	**Improved physician’s wording**	**Expected patient reaction**
Health status assessment	“From a medical point of view, you are healthy”	Feeling misunderstood, dismissed, frustration	“From a medical point of view, you are healthy, but your symptoms may be related to emotions and stress”	Understanding of symptom mechanisms, feeling that the whole context has been taken into account

Treatment options	"There is nothing more I can do here"	Helplessness, reduced sense of support	"I am not withdrawing from our contact. Referral to a specialist is a form of consultation."	Sense of support, reduced fear of rejection, readiness to cooperate
Referral to a specialist	"I would advise you to see a psychiatrist or psychologist"	Fear of a psychiatric diagnosis, resistance to the visit	"A consultation with a specialist who works with emotions will help better understand your symptoms. You can always come back to me"	Acceptance of the need for consultation, sense of safety and control over treatment

Physician-Patient Relationship in Working with Psychosomatic Patients - The Family Physician's Perspective

The physician-patient relationship plays a key role in an effective psychosomatic approach and constitutes one of the most important elements of the diagnostic and therapeutic process in family medicine practice. The quality of interpersonal contact significantly influences treatment effectiveness in both somatic and psychological dimensions [53]. Experience gained within Balint groups shows that difficulties in working with patients with psychosomatic disorders result not only from ambiguous clinical presentation but primarily from relational dynamics between physician and patient [53,54].

Patients with psychosomatic disorders often report numerous recurrent somatic complaints that lack clear confirmation in additional tests. Repeated visits, absence of objective indicators of improvement and organizational pressure foster physician frustration and may lead to emotional distancing from the patient [55,56]. Such reactions, although often unconscious, may be

perceived by the patient as rejection and may contribute to the intensification of psychosomatic symptoms.

An important factor sustaining the therapeutic relationship is the manner in which conversation is conducted. The effectiveness of contact depends not only on the content of information conveyed but also on the form of communication - pace of speech, tone of voice, intonation and skillful use of silence, which promotes patient reflection and introspection [21,57]. A physician who can create an atmosphere of safety, devote time to the patient and actively listen supports the patient's self-reflection process and mobilizes their own psychological resources [53].

A particular threat in the relationship with psychosomatic patients is the so-called "apostolic trap" described by Michael Balint [53], which involves the physician adopting an authoritarian role, imposing allegedly correct health and life attitudes on the patient. This mechanism fosters idealization of the physician, limits patient autonomy and may lead to dependency and symptom chronicity [58].

Therefore, the development of physician self-awareness is of key importance. A physician aware of their own personality traits, emotional reactions and limitations can more effectively cope with patient aggression, manipulation or excessive expectations and consciously use themselves as a "therapeutic tool" [59]. Participation in Balint groups enables analysis of one's reactions to patients, recognition of transference and countertransference mechanisms and identification of unconscious emotional blockages [60].

Systematic reflection on the physician-patient relationship within Balint training promotes empathy development, increases therapeutic communication effectiveness and reduces the risk of professional burnout. In family medicine practice, working with patients with psychosomatic disorders requires tolerance of uncertainty, awareness of one's own limitations and treating the therapeutic relationship as an integral part of the treatment process [21,54,60].

Summary

The psychosomatic approach requires holistic treatment of the patient, taking into account both physical therapy and psychological support. The physician-patient relationship becomes not

only a diagnostic means but also a therapeutic tool, in which the physician's time, attention, empathy and self-awareness play a crucial role in treatment effectiveness.

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